New Life
Healthcare LLC

• Physical Therapy
• Aquatic Therapy
• Work Injuries
• Sports Injuries

PATIENT DEMOGRAPHICS INFORMATION

DATE:_____

_____ _____ _____ (_____)_____
PATIENT'S LAST NAME FIRST NAME MIDDLE HOME PHONE

(_____)_____
CELL PHONE

_____ _____ _____ _____
CURRENT STREET ADDRESS CITY STATE ZIP

_____ _____
EMPLOYED BY EMPLOYER'S ADDRESS

_____ _____ _____
DATE OF BIRTH AGE GENDER: M F PREFER NOT TO SAY (CIRCLE ONE) OCCUPATION

EMAIL ADDRESS: _____ MAY WE USE YOUR EMAIL ADDRESS TO CONTACT YOU REGARDING YOUR APPOINTMENTS? (YES / NO)

MARITAL STATUS: ☐ SINGLE ☐ MARRIED ☐ WIDOWED ☐ SEPARATED ☐ DIVORCED

_____ _____ (_____)_____
EMERGENCY CONTACT NAME RELATIONSHIP EMERGENCY PHONE

WHO REFERRED YOU TO THIS OFFICE _____

ASSIGNMENT OF INSURANCE BENEFITS

I HEREBY IRREVOCABLY ASSIGN AND TRANSFER ALL BENEFITS WHETHER CONTRACTUAL, STATUTORY, OR COMMON LAW TO NEW LIFE PHYSICAL THERAPY, INC. FOR ALL AMOUNTS DUE ON MY CLAIM FOR SERVICES RENDERED TO ME OR MY DEPENDENT. I AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION NECESSARY TO PROCESS THIS CLAIM. I AM AWARE OF THE FACT THAT VERIFICATION OF INSURANCE BENEFITS IS NOT A GUARANTEE OF PAYMENT AND THAT I AM FULLY RESPONSIBLE FOR PAYMENT IN FULL IN THE EVENT MY INSURANCE CARRIER(S) DOES NOT COVER ANY OR ALL INCURRED CHARGES AT NEW LIFE PHYSICAL THERAPY, INC.

OUR OFFICE WILL BILL YOUR INSURANCE CARRIER(S) AS A COURTESY TO YOU. IF YOUR INSURANCE CARRIER SENDS PAYMENT DIRECTLY TO YOU, YOU WILL BE RESPONSIBLE TO FORWARD THESE PAYMENTS TO OUR BUSINESS OFFICE IMMEDIATELY UPON RECEIPT. ALL PATIENT BALANCES 60 DAYS PAST DUE WILL BE ASSESSED A FINANCE CHARGE.

_____ _____
RESPONSIBLE PARTY'S SIGNATURE DATE

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ADMISSIONS FORM

HISTORY AND PHYSICAL CONDITION INFORMATION

Answers to the following questions will assist the Therapist in providing a safe and effective program:

Date:_____

Name:_____**Age**:_____

Referring Physician:_____ **Primary Care Physician**: _____

Referring Physician Phone #:_____ **Primary Care Physician Phone #**:_____

Problems to be treated:_____

Have you had treatment for this problem before?: YES NO (Circle One)

If YES, Where:_____**When (Approx.)**:_____

Treatment received:_____

Have you had surgery associated with this problem?: YES NO (Circle One)

If YES, please list date and type of surgery: _____

List any major illness and/or surgery in the past year:_____ _____

Have you fallen in the past year?: YES NO (Circle One)

Are you currently taking any medications? YES NO (Circle One)

If YES, please list ALL medications: _____

Have you ever had Physical Therapy before? YES NO (Circle One)

Do you now have or have you ever had any of the following:

High Blood Pressure	YES	NO	**Cancer**	YES	NO
Heart Disease	YES	NO	**Allergies**	YES	NO
Heart Attack	YES	NO	**Hernia**	YES	NO
Pacemaker	YES	NO	**Seizures**	YES	NO
Diabetes	YES	NO	**Metal Implants**	YES	NO
Headaches	YES	NO	**Episodes of Dizziness**	YES	NO
Kidney Problems	YES	NO	**Balance Problems**	YES	NO
Nervous System Disorder	YES	NO	**Vision Problems**	YES	NO
Hearing Problems	YES	NO	**Incontinence**	YES	NO

If YES on any of the above, please explain and give approximate dates:

Do you have a medical condition that requires you to restrict your cardiovascular exercise: YES NO

Who referred you to New Life?: Friend Family Doctor Self Other_____

I certify that the information above is accurate to the best of my knowledge

Patient Signature:_____ **Date**:_____

Therapist Signature:_____ **Date**:_____

17122 Beach Blvd., Suite 101 Huntington Beach, CA 92647-5907 Ph: (714) 848-7191 Fax: (714) 375-7563

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PAIN CHART EVALUATION

PAIN DRAWING

Use the symbols below to visually mark the areas on your body where you feel the following sensations. Please try to include **ALL** affected areas.

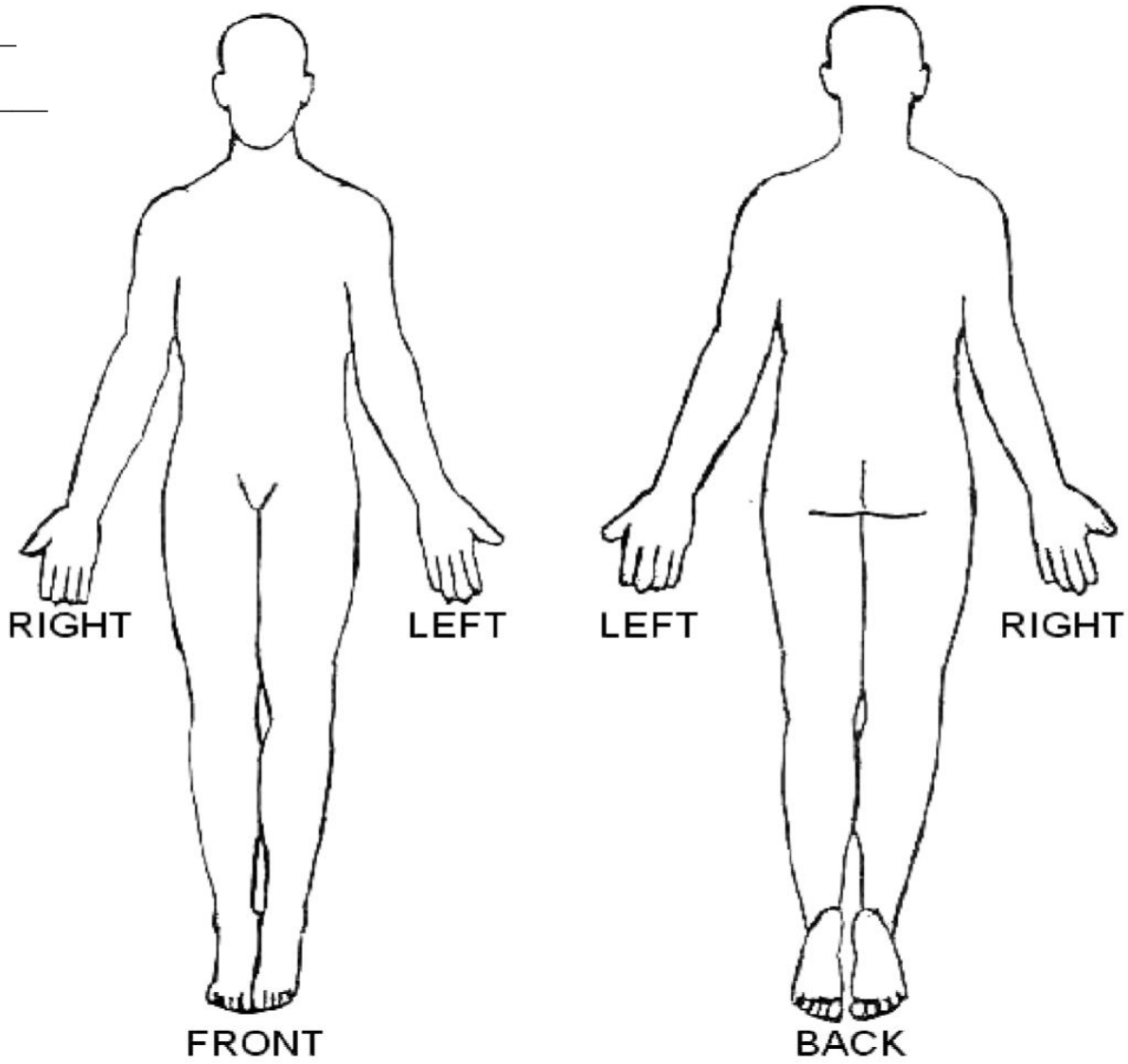
BURNING	NUMBNESS	PINS & NEEDLES	STABBING	ACHE
X	O	=	/	^

Best: _____

Worst: _____

Average: _____

PAIN LEVEL SCALE
0 = no pain – 10 = severe pain)



Therapist's Signature:_____ **Date**:_____

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NOTICE OF PRIVACY PRACTICES

This notice describes how your health information may be used and disclosed and how you can access this information. Please review it carefully.

The following information is being furnished to you as required under the Standards for Privacy of Individually Identifiable Health Information published by the U.S. Department of Health and Human Services at 45 C.F.R. parts 160 and 164 under the Health Insurance Portability and Accountability Act of 1996. Contact information for the U.S. Department of Health and Human Services is contained at the end of this notice.

1. At New Life Physical Therapy, Inc. (New Life), we have always kept your health information secure and confidential. A new law requires us to continue maintaining your privacy, to disclose your health information to those involved in your treatment. For example, we routinely share your continuing progress with your physician, to keep him updated as to your treatment here at New Life.

2. We may use or disclose your health information for payment of your services or disclose your health information for our normal healthcare operations. For example, one of our staff will enter your information into our computer. We may share your medical information with our business associates, such as a billing service. We have a written contract with each business associate that requires them to protect your privacy.

3. We may use your information to contact you. We may want to call and remind you of appointments. If you are not home, we may leave this information on your answering machine or with the person who answers the telephone. In an emergency, we may disclose your health information to a family member or another person responsible for your care. We may release some or all of your health information when required by law.

4. If this practice is sold, your information will become the property of the new owner. The new owner assumes the accountability for your protected health information.

5. Except as described above, the practice will not use or disclose your health information without your prior written authorization. You may request in writing that we not use or disclose your health information as described above. We will let you know if we can fulfill your request. You have the right to know of any uses or disclosures we make with your health information beyond the above normal uses.

6. As we will need to contact you from time to time, we will use whatever address or telephone number you prefer.

7. You have the right to transfer copies of your health information to another practice. We will make copies available for you to pick up. A nominal fee may be charged for copying or mailing.

8. You have the right to see and receive a copy of your health information, with a few exceptions. Give us a written request regarding the information you want to see. If you also want a copy of your records, we may charge you a reasonable fee for the copies.

9. You have the right to request an amendment or change to your health information. Give us your request to make changes in writing. We may or may not make the changes you request, but will be happy to include your statement in your file. If we agree to an amendment or change, we will not remove nor alter earlier documents, but will add new information.

10. You have the right to receive a copy of this notice.

11. If we change any of the details of this notice, we will notify you of the changes in writing.

12. You may file a complaint with the Department of Health and Human Services, 200 Independent Avenue, S.W., Room 509F, Washington DC, 20201. You will not be retaliated against for filing a complaint.

13. However, before filing a complaint, or for more information or assistance regarding your health information privacy, please contact our office at (714) 848-7191.

This notice goes into effect as of April 14, 2003.

I have read and acknowledged and understand New Life Physical Therapy, Inc. Notice of Privacy Practices.

Patient Signature	Print Name	Date

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LATE CANCELLATION AND NO-SHOW POLICY

Effective January 1, 2024

Our goal is to provide quality physical therapy treatment. When appointments are missed or canceled without a timely notice, it leaves openings that could be used by other patients.

We strive to make every effort to remind you of your appointments. It is necessary for you, as the patient, to cancel your appointment in a timely manner.

Therefore, we require that you please notify us of your cancellation at least **24 HOURS** in advanced. This allows us time to allocate that appointment to another patient. If your attempt to notify us is not met (ie. we are closed or out of the office), please leave a message on our answering machine with details as to why you are cancelling and for which day(s). We will get back to you as promptly as possible.

Please note that if a timely notification is not given or if you fail to show up to your appointment, you will be charged a $50.00 cancellation fee.

Thank you very much for your cooperation.

I, the patient, agree to the cancellation and no-show policy set forth above

Patient Signature:_____ **Date**:_____

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CONSENT TO TREAT AUTHORIZATION

I, _____ do hereby consent to be treated for physical therapy by New Life Physical Therapy.

Patient Signature: _____ **Date**: _____